To Enroll in <plan>, Please Provide the Following Information:			
[Optional Field] **Please check which plan you want to enroll in:** ____ Product ABC $XX per month ____ Product XYZ $XX per month			
LAST name: FIRST Name: Middle Initial			☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	Sex: ☐ M ☐ F	Social Security Number: *(providing this information is optional)*	Home Phone Number: ( )
Permanent Residence Street Address:			
City:	State:		ZIP Code:
Mailing Address (only if different from your Permanent Residence Address): Street Address: City: State: ZIP Code:			
Emergency contact: [Optional field] _____ **Phone Number**: [Optional field]_____ **Relationship to You** [Optional field]_____			
[optional field] **E-mail Address:**			
Please Provide Your Medicare Insurance Information			

Please take out your Medicare Card to complete this section. • Please fill in these blanks so they match your red, white and blue Medicare card - OR - • Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board. You must have Medicare Part A and Part B to join a Medicare Advantage plan.	MEDICARE HEALTH INSURANCE SAMPLE ONLY Name: _____ Medicare Claim Number Sex ___ __ __ __ - __ __ - __ __ __ __ ___ Is Entitled To Effective Date **HOSPITAL (Part A)** _____ **MEDICAL (Part B)** _____

Your Plan Premium Option

You can have the monthly premium for this Medicare plan automatically deducted from your Social Security check. If you don't choose this option, we will send you a bill each month which you can pay by mail or by electronic Funds Transfer (EFT). *<Optional – insert other billing interval options, if available>* Generally you must stay with the option you choose for the rest of the year.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium. Please choose if you want the remaining premium, if there is any, deducted from your monthly check.

Would you like the premium for this plan deducted from your SSA monthly benefit check. ☐ Yes ☐ No

Please read and answer these important questions:

1. Do you have End Stage Renal Disease (ESRD)? ☐ Yes ☐ No

If you answered "yes" to this question and you do not need regular dialysis any more, or have had a successful kidney transplant, **please attach a note or records** from your doctor showing you do not need dialysis or have

had a successful kidney transplant.

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to <MA plan>? ☐ Yes ☐ No
If “yes”, please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: _____ ID # for this coverage: _____ Group # for this coverage _____

3. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No
If “yes” please provide the following information:
Name of Institution: _____
Address & Phone Number of Institution (number and street):_____

4. Are you enrolled in your State Medicaid program? ☐ Yes ☐ No
If yes, please provide your Medicaid number: _____

5. Do you or your spouse work? ☐ Yes ☐ No

[Optional field] Please choose the name of a Primary Care Physician (PCP), clinic or health center (if required):

[Optional field] **Please check one of the boxes below if you would prefer us to send you information in a language other than English:**

____ Language A (e.g., Spanish)

____ Language B (e.g., Chinese)

[Following box only required for MA-PD plans:

Please Read This Important Information

If you currently have health coverage from an employer or union, joining <MA-PD Name> could affect your employer or union health benefits. If you have health coverage from an employer or union, joining <MA-PD Name> may change how your current coverage works. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please Read and Sign Below:

By completing this enrollment application, I agree to the following:

<Name> is a Medicare Advantage plan and I will need to keep my Parts A and B. I can only be in one Medicare Advantage plan at a time. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to <Name> or by calling 1-800-Medicare. TTY users should call 1-877-486-2048.

<Name> serves a specific service area. If I move out of the area that <Name> serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of <Name>, I have the right to appeal plan decisions about payment or services if I disagree. I will read the [insert either Member Handbook or Evidence of Coverage document] from [name] when I receive it to know which rules I must follow in order to

receive coverage with this Medicare Advantage plan.

[*MA PFFS do not include the following paragraph]* I understand that beginning on the date [name of plan] coverage begins, I must get all of my health care from [name of plan], with the exception of emergency or urgently needed services or out-of-area dialysis services. Medicare beneficiaries are generally not covered under Medicare while out of the county except for limited coverage in Canada and Mexico. Services authorized by [name of plan] and other services contained in my [name of plan] Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR [NAME OF PLAN] WILL PAY FOR THE SERVICES.**

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by <MA Plan> or by Medicare.

Your Signature:	**Today's Date:**

If you are the authorized representative, you must provide the following information:

Name : _____
Address: _____
Phone Number: (___) ____- _____

Relationship to Enrollee _____

Office Use Only:
Name of staff member (if assisted in enrollment):_____
Plan ID #:_____
Effective Date of Coverage: _____
ICEP/IEP: _____ OEP: _____ AEP: _____ SEP (type): _____